

Rich Presser, DDS • Steve Regan, DDS • Rob Chenoweth, DDS • Aaron Light, DDS

**PATIENT INFORMATION**

Name: _____		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: ___/___/___	SS#: _____
Preferred Name: _____		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other		
Address: _____		City: _____	State: _____	Zip: _____
Cell #: _____	Home#: _____		Work#: _____	
Email: _____		Employer: _____		
Physicians Name: _____		Phone#: _____		
Emergency Contact: _____		Phone #: _____	Relationship: _____	
<input type="checkbox"/> It is OK to send appointment reminders by text?		<input type="checkbox"/> It is OK to send appointment reminders by email?		
If patient is under 18, provide guardian's name/ person responsible for account: _____				
How did you hear about our office?		<input type="checkbox"/> Google	<input type="checkbox"/> Insurance _____	Other: _____
		<input type="checkbox"/> Website	<input type="checkbox"/> Referred by: _____	

**DENTAL INSURANCE**

Dental Insurance? <input type="checkbox"/> Y <input type="checkbox"/> N Insurance Company: _____ ID#: _____ Grp#: _____
If not self, Policy Holder's Name: _____ DOB: ___/___/___ Employer: _____
I authorize release of any information relating to all dental claims and understand that I am responsible for all costs of dental treatment regardless of what insurance pays. I understand that all co-payments/deductibles are due at the time of treatment. I hereby authorize payment of dental benefits otherwise payable to me directly to Summit Dental Group
Patient/Guardian Signature: _____ Date: ___/___/___

**DENTAL HISTORY**

<p><b>Check any of the following problems that currently apply to you:</b></p> <p><input type="checkbox"/> Sensitivity (hot,cold,sweets)</p> <p><input type="checkbox"/> Tooth ache pain</p> <p><input type="checkbox"/> Broken teeth or broken fillings</p> <p><input type="checkbox"/> Bleeding, swollen, or sore gums</p> <p><b>Have you ever been treated for gum disease?</b> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><b>When was your last:</b> Cleaning? _____ X-Rays? _____</p> <p>Previous Dentist: _____</p> <p>Why did you leave? _____</p>	<p><b>Do you smoke or use chewing tobacco?</b> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>How Much? _____ For how long? _____</p> <p><b>If I could change my smile, I would:</b></p> <p><input type="checkbox"/> Make them whiter</p> <p><input type="checkbox"/> Make them straighter or close spaces</p> <p><input type="checkbox"/> Replace missing teeth</p> <p><input type="checkbox"/> Replace old crowns that do not match</p> <p>Questions/Concerns for the doctor? _____</p> <p>_____</p> <p>_____</p>
---	---

## HEALTH HISTORY

**Please check any of the following that apply to you:**

<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Anemia <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disease <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy/Radiation <input type="checkbox"/> Chest Pain/Angina	<input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Emphysema <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart Condition/Surgery <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Hepatitis A,B, or C <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Immune Problems <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Seizures <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Other _____
--	--	---	--

## MEDICATIONS

<p><b>Are you taking any medications?</b> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>List of medications: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>WOMEN ONLY :</b></p> <p><b>Are you taking oral contraceptives?</b> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>If you are using oral contraceptives, it is important for you to know that antibiotics may interfere with your birth control's effectiveness. You will need to use mechanical forms of birth control for one complete cycle after you finish taking your antibiotics. Please consult with your physician for further guidance. <b>INITIALS:</b> _____</p>
<p><b>Are you or have you taken prescription medications for osteoporosis or bone cancer?</b> <input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p><b>Are you pregnant or is there a chance you may be?</b> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Due Date: ____/____/____</p>
<p><b>Does your physician require you to be pre-medicated with antibiotics prior to dental treatment for any reason?</b> <input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p><b>Are you nursing?</b> <input type="checkbox"/> Y <input type="checkbox"/> N</p>

## ALLERGIES

**Mark any known allergies:**

<input type="checkbox"/> Sulfa	<input type="checkbox"/> Latex	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Other: _____
--------------------------------	--------------------------------	-------------------------------------	---	---------------------------------------

## SLEEP /TMJ ASSESSMENT

<b>SLEEP</b>	
Is it easy for you to fall asleep?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you wake often during the night?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you feel rested upon waking?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you been told that you snore while sleeping?	<input type="checkbox"/> Y <input type="checkbox"/> N
Has anyone ever seen you stop breathing while sleeping?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you use or have you ever tried sleeping with a CPAP or APAP?	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>TMJ</b>	
Do you experience pain in your jaw and/or around your ears?	<input type="checkbox"/> Y <input type="checkbox"/> N
Does your jaw make popping or clicking sounds when your jaw moves?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you wake up with headaches in the morning or do headaches frequently develop in the evening?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you grind your teeth at night?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you prone to neck or shoulder pain?	<input type="checkbox"/> Y <input type="checkbox"/> N

**I understand that a thorough health history is important to assist the doctors in providing the safest care possible, and have answered all questions truthfully and to the best of my ability.**

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Printed Name: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You may refuse to sign this acknowledgement.**

I, \_\_\_\_\_ have received a copy of Summit Dental Group's Notice of Privacy Practices.

The following people have my permission to obtain information that is protected by the HIPAA Privacy Notice:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

***I DO NOT ALLOW ANYONE ACCESS TO MY INFORMATION.***

Patient's Printed Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining acknowledgement

Other (Please specify) \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## WRITTEN FINANCIAL AND APPOINTMENT POLICIES

---

Thank you for choosing Summit Dental Group! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options: Check, Cash, all Credit Cards or Care Credit (subject to credit approval). We also offer a 5% discount off of your co-pay if it is paid at the time that your appointment is scheduled. **NO DISCOUNTS OR PRE-PAYMENT COURTESIES OFFERED FOR PAYMENTS MADE WITH CARE CREDIT.**

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. However, **all co-pays or estimated portions are due at the time of service.** If we receive more than is estimated from insurance, we will promptly issue a refund to you. **In the event that your insurance pays less than is estimated, the new balance due will be your responsibility.**

Any overdue balance not paid within 30 days will be subject to a finance charge of 1.5% monthly (18% annually). Any account with a patient balance over 90 days old may be turned over to a collection agency for collection and any fees charged by the agency and/or attorney's fees will be the patient's responsibility.

Summit Dental Group requires payment at the beginning of treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. Summit Dental Group charges \$25 for returned checks.

### APPOINTMENT POLICIES:

In our office, we value the time appointed for all of our patients. Therefore, if you arrive more than 15 minutes late to your scheduled appointment, we reserve the right to reschedule your appointment out of respect to the next scheduled patient. Further, **all cancellations need to be made at least 24 hours in advance** or it will be considered a failed appointment. Failing two (2) appointments may result in a patient NOT being scheduled for any further treatment in our office.

Due to space limitations in the treatment rooms, we prefer children not to be accompanied by a parent/guardian unless special arrangements have been authorized. All other siblings **MUST** remain supervised in the waiting area until called for their appointment.

If you have any questions, please do not hesitate to ask. We are here to help you obtain the treatment that you want or need.

By signing below, I have read and understand the information presented, and all of my questions have been answered.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Printed Name: \_\_\_\_\_